SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

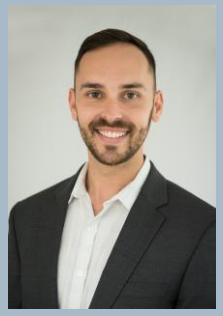
Workforce Development Part 2: Making the connection through integrated behavioral health workflows

January 31, 2018

SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Moderators:

Andrew Philip, PhD, Deputy Director, CIHS



Roara Michael, Senior Associate, CIHS

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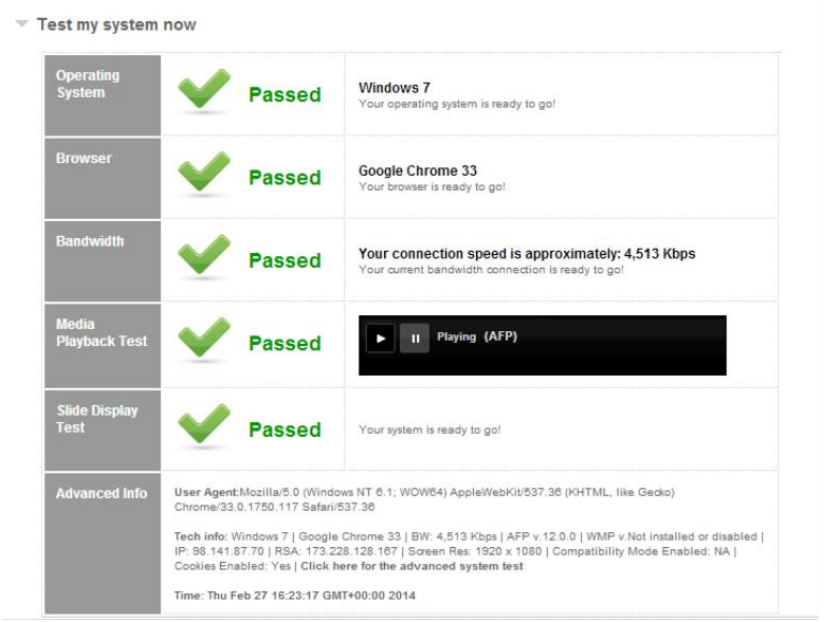

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Learning Objectives

After this webinar, participants will be able to:

- Recognize the role of behavioral health providers as leaders and key agents in working with other disciplines
- Examine methods for involving new staff in continuous quality improvement cycles and monitoring
- Identify commonly used protocols and procedures for effective and efficient clinic workflows while also avoiding provider burnout
- Map workflow processes to support key evidence-based practices such as motivational interviewing and cognitive behavioral therapies

Today's Speakers

Virna Little, PsyD, LCSW-R, MBA, SAP
Associate Director of Strategic Planning,
Center for Innovation in Mental Health at
City University of New York

Jonathan Muther, PhD
Director of Behavioral Health and
Psychology, Salud Family Health Centers

Poll Question 1

1. I am a:
    a) primary care clinician
    b) behavioral health provider
    c) clinic administrator
    d) health system or health center director/executive
    e) other

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Creative Workforce Retention

Virna Little, PsyD, LCSW-r, SAP, CCM

Workforce Retention

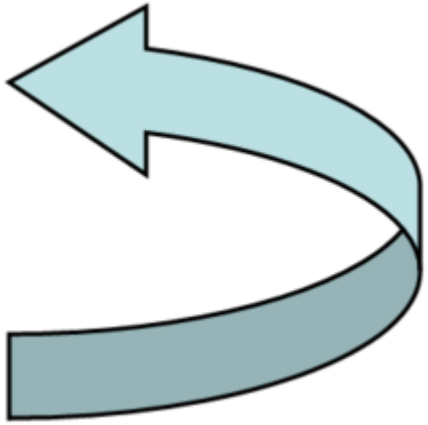
- One size does not fit all !!
- Different disciplines
- Different ages and career stages
- List positions and brainstorm individually

How Will You Know You're Successful ?

- Do you measure retention rates ?
- General satisfaction surveys " yes I am satisfied " vs. using a scale for different questions
- Be able to measure and review different categories
- Is this a CQI project ?

Return on Investment

- Does a broad scale training for all staff (DBT) have the most ROI or would you be better to select a few and invest in “trainers” ?
- Wellness activities – how will your measure impact on retention ?



The Evaluation Process

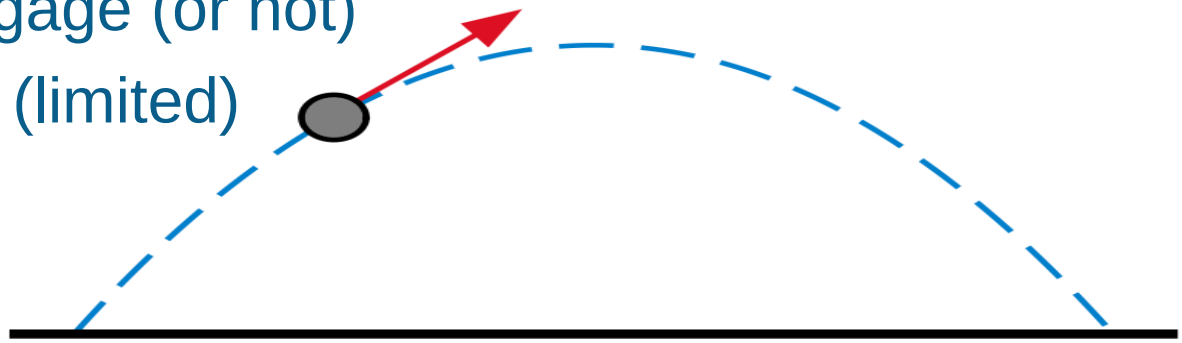
- Similarities to “treatment planning” as a living document
- Training supervisors to a lot time and to complete evaluations
- SMART goals that last throughout evaluation period and including events from across evaluation period
- Taking the opportunity to talk about career “if you were going to spend your career here what would that look like?”
- The caring letter-its not just for patients anymore !

Staff Development and Training

- People love to learn and grow
- Not everything costs – utilize free sources for EBP's
- Develop in house experts and trainers (play therapy)

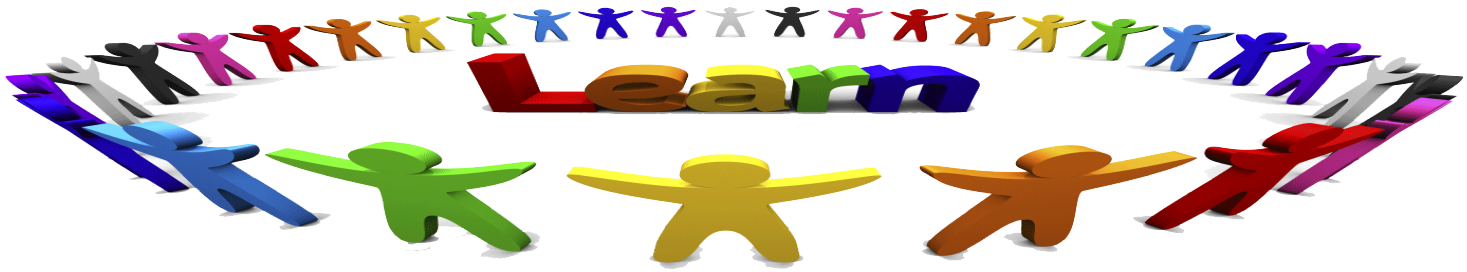
Create Clear Trajectories

- Committee membership to leader to manager as a stepped process
- What goes up does not come down !
- Repurpose, repurpose, repurpose
- Committees such as compliance, EBP, environment of care, emergency prep, research etc.
- Secondary gain of committees – interactions, experience to see staff engage (or not)
- Coordinator (limited)



Some Lessons Learned

- Training professional skills
- Create diverse positions- Psychiatry
- Calculate sustainable patient care % and utilize FTE for staff as opportunity for special positions like informatics
- Don’t do a survey unless you have an action plan first
- Tiger teams to solve biggest staff “problems”, engaging stakeholders as a “special” selection



Questions ?

Salud Family Health Centers

EXCELLENCE. EVERY PATIENT. EVERY TIME.

Behavioral Health Providers on Behavioral Health Integration Workflow

Jonathan Muther, PhD

Vice President of Medical Services – Behavioral Health, Salud FamilyHealth Centers

Clinical Integration Advisor, Eugene Farley Jr. Health Policy Center, UC-Denver

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Definition

The care that results from a *practice team* of primary care *and* behavioral health clinicians, *working together with patients* and *families*, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address *mental health, substance abuse* conditions, *health behaviors* (including their contribution to chronic medical illnesses), *life stressors and crises*, stress-related *physical* symptoms, ineffective patterns of health care *utilization*.

Value of Integration:

Physical/Behavioral Integration is good health policy and good for health.

Peek, C. J., National Integration Academy Council. (2013). Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. In Agency for Healthcare Research and Quality (Ed.), *AHRQ Publication No.13-IP001-EF*.

Behavioral Health Overview

Salud Family Health Centers

Integrated Model of Care

- ≠ Co-located, consultative model
- = Behavioral Health Provider; shared responsibility; team-based care

Quadruple Aim Oriented

Scientist – Practitioner

- Empirically-supported interventions; Generalist clinicians treating broad spectrum
- Measuring outcomes; Evaluating team-based model of care

Cultural Competence & Awareness of Health Disparities

- Bilingual BHP's, awareness of barriers to treatment, reducing stigma


Better care
More satisfied patients
Lower total medical costs
More satisfied providers

BH Access Gap

Demand for services

Supply of clinicians

Significant disparities exist between the *need* for BH services and *access* to BH care

- In 2016, 47% of adults with a mental illness and 89% of adults with a substance use disorder did not receive treatment

Nardone M, Snyder S, Paradise J. Integrating physical and behavioral health care: promising Medicaid models. The Kaiser Commission on Medicaid and the Uninsured, February 12, 2014. (http://kff.org/report-section/integrating-physical-and-behavioral-health-care-promising-medicaid-models-issue-brief/).

- 56% of adults with a behavioral health disorder do not get behavioral health treatment

Nguyen, Theresa, et al. *State of Mental Health in America 2018,* Mental Health America, 2017. http://www.mentalhealthamerica.net/issues/state-mental-health-america

- "An estimated 13-20% of children in the United States (up to 1 out of 5 children) experience a mental disorder in a given year…"

Centers for Disease Control and Prevention. Mental health surveillance among children –United States 2005-2011. MMWR 2013;62 (Suppl; May 16, 2013):1-35. The report is available at www.cdc.gov/mmwr

APPENDIX FF Behavioral Health Penetration Rates

AGE_GROUP	FY 13/14 Penetration Rate	FY 14/15 Penetration Rate	FY 15/16 Penetration Rate
Adult 21-64	17%	16%	15%
Child Under_21	8%	8%	9%
Elderly 65 and older	5%	7%	6%

https://www.colorado.gov/pacific/hcpf/accphase2

Patient Variables:

Why Aren't Coloradans Getting the Mental Health Services They Need?

	2013	2015	2017
Uninsured*	77.5%	65.2%	72.4%
Concerned about the cost	75.6%	57.3%	56.1%
Didn't think health insurance would cover it**	55.3%	43.3%	43.1%
Difficulty getting an appointment	30.5%	34.0%	35.2%
Don't feel comfortable talking about personal problems with a health professional	31.0%	40.2%	31.4%
Concerned about someone finding out you have a problem	19.8%	27.6%	22.0%

* Asked of uninsured during the past year ** Asked of those insured during the past year

https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2017%20CHAS%20DESIGN%20FINAL%20for%20Web.pdf

Quality

- Only 30% of behavioral health quality workers report skills in both basic research and quality-specific skills (McMillen & Raffol, 2016)
- Behavioral health quality professionals may be ill-prepared to help their…agencies achieve the kinds of quality targets necessary to survive in a transition to a value-based payment environment (McMillen & Raffol, 2016)

BH quality measures

- Access - Penetration rate into total Salud population, percent of unique pt's seen by total BH staff (e.g. what % of primary care patients have been seen by BHP?)

$$\% = \frac{\text{Seen by BHP (any visit type)}}{\text{Total Salud population}}$$

Goal: baseline, then work to 30%

- Access - % unique patients in BHPs schedule, by individual BHP

$$\% = \frac{\text{Unique pt by BHP}}{\text{All pt's seen by that BHP}}$$

Goal: quarterly, want to see 30% new patients. This shows a positive level of flux in the BHP practice – they are not just seeing the same patients over and over again.

*Acknowledgement: Parinda Khatri, PhD & Jean Cobb, PhD. Cherokee Health Systems

Allow for the Blending of Cultures

BioMedical/
Psychotherapy

→

BIOPSYCHOSOCIAL

Disease Response w/ Meds

Traditional Hierarchies

Telling the Pt what to do

Fern & Lamp Therapy Hour

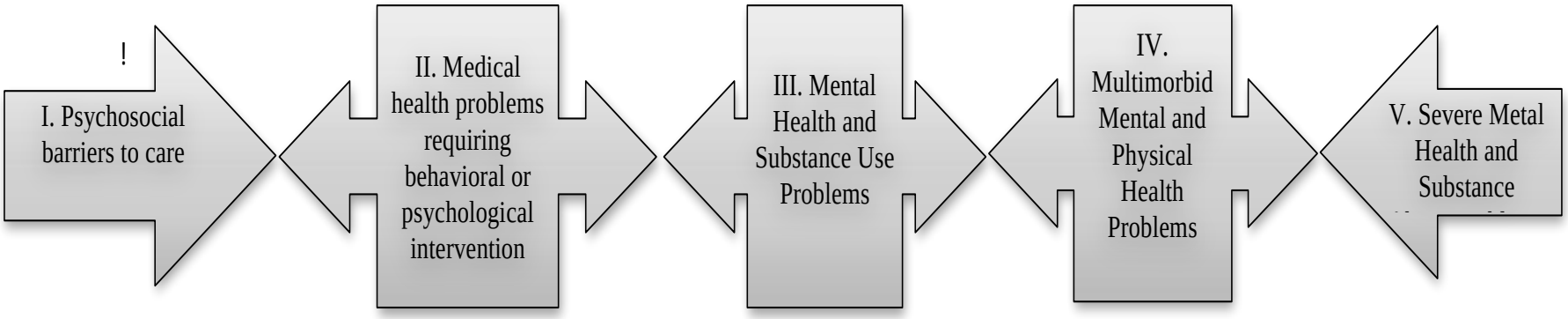
Prevention & Wellness

Equal responsibility for *HEALTH*

Asking what they think is best

Rapid Assessment & Brief Episodes of Care

The Range of Needs that BH can Address



Miller, Brown Levey, Payne-Murphy, & Kwan, (2014). Outlining the scope of behavioral health practice in integrated primary care: dispelling the myth of the one-trick mental health pony. *Family, Systems & Health,* 32(3):338-43.

Services We Provide

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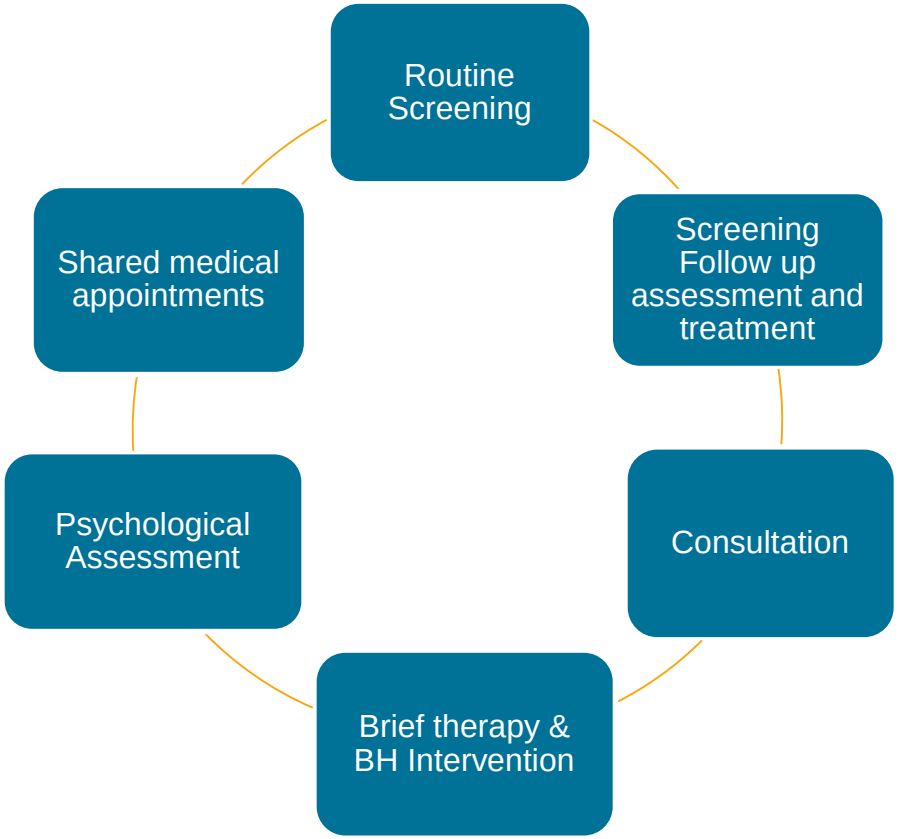

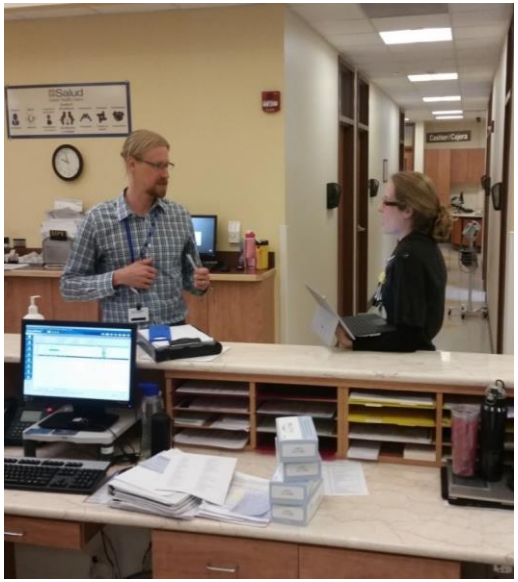

BH Screening

- To identify and address Behavioral Health issues that would otherwise go unidentified and unaddressed
- It is an encounter *not* requested by PCP/care team and not *expected* by the patient
- Tests that look for diseases before you have symptoms. Screening tests can find diseases early, when they're easier to treat (NIH)

BH Screening

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❑ Outcome Rating Scale (ORS) → Baseline functioning/distress

Screen for Life Stressors & Outcome Rating Scale

- Depressed mood
- Anhedonia
- Nervous/tense
- Worry
- Marijuana
- Illicit drugs & Rx misuse
- etoh abuse per episode
- etoh abuse per week
- Trauma (PC-PTSD)
- Domestic violence

Follow up Measures

Dep → PHQ-9

Anx → GAD-7

SA → DAST

etoh → AUDIT

PCL

BH Consultations

What consultation is:

- At the request of the PCP or other member of the care team
- Responding to a concern that has already been recognized
- Both assessment *and* intervention-based encounter
- Designed to respond to aspects of overall *health*, not just mental health

What consultation is *not*:

- Treating the PCP as the "client"
- An "adjunct" or "ancillary" service
- ….the only thing we do
- "Therapy" though can take place in succession, e.g., follow up at next med appointment

Consultation example:

History of Present Illness

~Depression Screening:

PHQ-9

Thoughts that you would be better off dead, or of hurting yourself in some way *Not at all*

Total Score *14*

Intepretation *Moderate Depression*

BH Visit Details:

Pt is a [redacted] y.o. English-speaking woman referred for a BH consult d/t endorsing depressive sxs in her medical appointment as a reason for why she is not effectively managing her diabetes. Pt states she has felt depressed for "2-3 months" an[redacted]. Pt endorses sleeping 1-2 hours a night, eating once per day, feeling unmotivated, anhedonia and hopelessness. She denies SI/HI, anxiety sxs and reports no substance use. Pt states she had therapy once in the past with a male BHP and "didn't feel a connection." She endorses a trauma hx from childhood that does not cause current PTSD sxs. Notes she is recentl[redacted] married to a "very supportive and kind" husband and he is concerned about her mood. Pt cites when she is at work as the only time she is "happy and able to not worry about my children." Pt works part-time.

Pt appears cooperative in session. Her mood is "down, I have no motivation" and her affect tearful. She exhibits good judgement and reality testing and fair insight into her condition.

Pt endorsing several depressive sxs (see above) and appears to meet criteria for MDD though more thorough assessment should be conducted so dx deferred at this time. Depressive sxs and diffuse boundaries with her daughters appear to be affecting her sleep and ability to care for her physical health. Pt is amenable to BH therapy and arranged to meet with this provider on 9/5/1[redacted] for a 1st session. She was also referred to the BH Sleep Group and asked to get out of bed when sh[redacted] notices herself worrying at night. Dr.[redacted] her medical provider) was informed of the plan and my impressions.

Session Start Time ---8:45am.

Session End Time ---9:10am.

Duration of Encounter ---25 min.

Session Setting (Place of Service) FQHC.

Type of Contact: ---, Requested Consult.

Mode of Treatment ---, Face-to-Face.

Assessments

1. Illness, unspecified - R69 (Primary)

Labs

Lab: BH - Outcome Rating Scale (ORS)	BH - Clinical
Individually	2
Interpersonally	.9
Socially	7.5
Overall	3
Total	13.7

[redacted]

Procedure Codes

H0031 MENTAL HEALTH ASSESS NON-PHYSICIAN

Follow Up

2 Weeks

Case example: Therapy follow up

BH Visit Details:

Pt is a [redacted]y.o. English-s
morning after a BH consult
medical appointment as a
her mood and degree of m
large part to our meeting.
down from 260 to 140." Pt
night d/t only using her be
putting up better boundar
she endorses adding one m
anhedonia, low self-worth

Assessments

1. Major depressive disorder, recurrent episode, moderate - F33.1 (Primary)

Labs

Lab: BH - Outcome Rating Scale (ORS)	BH - Clinical
Individually	7
Interpersonally	4.8
Socially	9
Overall	7
Total	27.9

[redacted]

Lab: BH - Session Rating Scale (SRS)	BH - WNL
Relationship	10
Goals and Topics	10
Approach or Method	10
Overall	10

[redacted]

Procedure Codes

90837 Psychotherapy, 60 minutes

Follow Up

1 Week

Core Competencies for Behavioral Health Providers working in Primary Care

- *Identify and assess* behavioral health *needs* as part of a primary care team
- *Engage and activate patients* in their care
- Work as a primary care team member to create and implement *care plans that address behavioral health factors*
- Help observe and *improve care team function* and relationships
- *Communicate effectively* with other providers, staff, and patients
- Provide efficient and effective *care delivery that meets the needs of the population* of the primary care setting
- Provide culturally responsive, whole-person and family-oriented care
- Understand, value, and adapt to the *diverse professional cultures* of an integrated care team

▪http://farleyhealthpolicycenter.org/wp-content/uploads/2016/02/Core-Competencies-for-Behavioral-Health-Providers-Working-in-Primary-Care.pdf

Resources

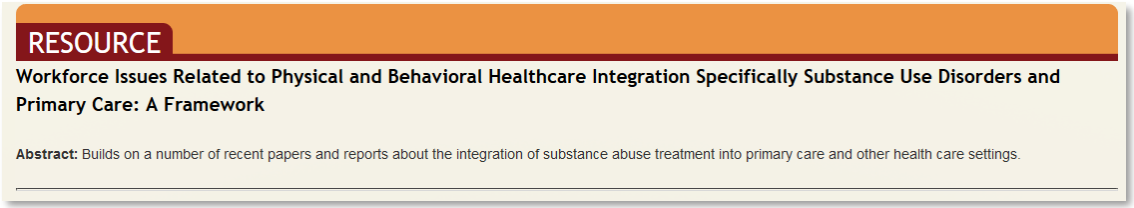
- Essential: http://integrationacademy.ahrq.gov/
- Essential: https://www.samhsa.gov/integrated-health-solutions
- Value of Integration & Competencies: https://makehealthwhole.org/
- Case study: http://www.advancingcaretogether.org/
- Webinar: http://www.youtube.com/CUDFMPolicyChannel
- National organization: http://www.cfha.net/
- Outcome Measure: https://www.heartandsoulofchange.com/
- Policy: http://farleyhealthpolicycenter.org/

Questions ?

Poll Question 2

1. Following this webinar, I plan to:
   a) review my current workflow/procedures
   b) revise or make changes to existing workflow/procedures
   c) Share this information with others involved in workflow practices

Additional Resources



CIHS Tools and Resources

Visit www.integration.samhsa.gov or e-mail integration@thenationalcouncil.org

- Core Competencies for Integrated Behavioral Health and Primary Care
- Primary and Behavioral Health Integration: Guiding Principles for Workforce Development
- Building cultural competence in healthcare
- Sample Job Descriptions

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